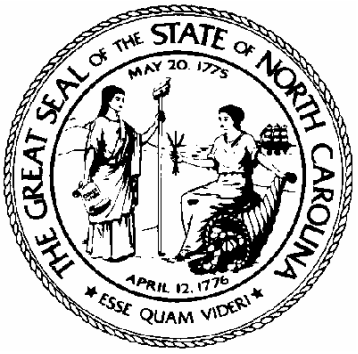

2007 Annual Report

Review of the

North Carolina Department of Correction
Division of Alcoholism and Chemical Dependency Programs
Division of Prisons – Health Services
Mental Health Section

General Statute 148-19 (d)

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and
Substance Abuse Services

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I. Historical Overview of MH/DD/SA Services in the Division of Prisons

The North Carolina Department of Correction (DOC) has the responsibility to deliver comprehensive mental health, developmental disabilities and substance abuse services (MH/DD/SAS) which provide for the care and treatment of inmates. Over the years, the DOC has expanded the MH/DD/SA services that are available to inmates. Mental health services were first provided for inmates in the DOC in 1965; however, the first mental health ward was not established until one was added to Central Prison in 1973. In 1985, a North Carolina Legislative Research Commission reported that over 67% of criminal offenses were directly connected to alcohol and drug use and found that treating addiction was imperative since most offenders will eventually leave prison. For this reason, the Substance Abuse and Chemical Dependency Program (SACDP) was created by the Division of Alcoholism and Chemical Dependency Programs (DACDP). From this sprung the Drug Alcohol Recovery Treatment (DART) program in January of 1988 at Wayne Correctional Center. Since then, DART has provided an opportunity for offenders to engage in treatment and recovery. In 1991, the first residential sex offender treatment program was established at Harnett Correctional Institute. The DOC has also begun providing non-residential sexual offender treatment for inmates and follow-up services for inmates who complete the residential program and are transferred back to their original units. In 1997, a federal grant began funding in-prison, long-term Residential Substance Abuse Treatment programs (RSAT). In 2006-07, the RSAT programs at Morrison, NC Correctional Institution for Women (NCCIW), Western Youth and Rowan were converted from Federal to State funding.

II. Overview of Current MH/DD/SA Services in the Division of Prisons

The DOC's stated mission for MH/DD/SAS is to deliver "multi-disciplinary services designed to prevent, control, reduce or eliminate those conditions which contribute to the inmate's mental impairment." Inmates can gain access to MH/DD/SAS through several avenues, such as during initial medical screenings at diagnostic centers or at any time during incarceration by inmate or prison staff request.

Mental Health Services

The DOC has established a systematic means whereby to standardize the type of service and level of mental health (MH) care provided inmates. Each facility is assigned a Mental Health Grade (M Grade), which determines the type of MH services the facility is allowed to provide. The M Grades and definitions are as follows:

Mental Health Grades

M Grade	Definition
1	No MH treatment provided; inmates needing MH services are transferred to a M2, M3, M4 or M5 facility, as appropriate.
2	Only outpatient treatment provided for mild mental illnesses by a psychologist or clinical social worker.
3	Only outpatient treatment provided for mild mental illnesses by a psychologist or clinical social worker; no limitations on work assignment.
4	Residential treatment provided; inmates transferring facilities or requesting major program changes must first be approved by MH staff.
5	Inpatient treatment provided; inmates transferring facilities or requesting major program changes must first be approved by MH staff.

See **Appendix A** for a chart that provides an overview of the M Grade(s) of each facility in the state. The available MH services fall into one of the following five categories: crisis/emergency, prevention, outpatient, residential, and inpatient services.

Crisis and Emergency Services are one of the MH services provided inmates by the DOC. Most facilities have crisis services protocol in order to effectively handle an MH emergency. For instance, outpatient MH services assists with the management of suicidal or self-injurious inmates. Programs offering this service are required to have at least one staff member who will respond to an emergency twenty-four hours a day, seven days a week. The staff member who is on call can be reached immediately by pager.

Prevention services are designed to use psycho-educational training to provide inmates with the tools necessary to prevent MH emergencies and to aid the inmate in adjusting to prison life.

Outpatient mental MH services include everything from simple evaluation and treatment of situational disorders to intensive management of serious and life-threatening mental illnesses. Treatment modalities include individual and group psychotherapy using a variety of theoretical systems, cognitive-behavioral therapies, psychotropic medication administration, psycho-educational training programs, and relapse prevention programs.

Residential services are provided at four facilities in the state. These facilities offer long-term MH services for inmates who have serious, chronic mental illnesses. Adult male felons are housed at Eastern, Hoke, or Foothills. Youth offenders also housed at Foothills, and female felon offenders reside at the North Carolina Correctional Institution for Women (NCCIW). Treatment and activity programming is analogous to that provided at state psychiatric hospitals and includes individual and group psychotherapy, psychotropic medications, activity therapies, mental illness education and relapse prevention training, and social skills training. Inmates who make satisfactory extended adjustment within the residential program but who continue to require frequent intervention by MH staff may be transferred into a day treatment program, which is for inmates with chronic, less severe mental illnesses. Those inmates who make a full recovery to pre-morbid levels of functioning may be transferred back to the original prison unit from which they were initially referred.

Inpatient services are provided for inmates who are acutely mentally ill. Male inmates are treated at a unit in Central Prison and females at NCCIW. Inpatient services include psychotropic medications, individual and group psychotherapy, activity and rehabilitation therapy, and MH nursing services. Once inmates' mental disorders are stabilized, they may be transferred back to their regular prison units for outpatient follow-up. Inmates requiring an intermediate level of inpatient care are transferred to a long-term residential MH facility. Some inmates with long-standing mental illness or developmental disabilities who require frequent MH intervention and programming but are able to function within the general prison population may be transferred to a day treatment program.

Services for Developmental Disabilities and/or Mental Retardation

Many inmates are in prison because of diminished judgment and reasoning abilities. In some cases the inmates may be developmentally disabled (DD) or intellectually disadvantaged and

require continual monitoring of assignments and structuring of all daily activities in order to function effectively and be able to re-enter society successfully. Treatment activities include individual and group psychotherapy, psychotropic medication education and administration, and training in various work assignments to keep inmates active and productive. Other services for inmates with DD include: interpreters for the deaf, specialized case management for mentally retarded, appliances for the physically handicapped, and communications devices for those with needs for them.

Inmates with suspected DD identified at the diagnostic centers are referred to the Day Treatment Program at Pender. The Pender facility objective is to provide services for inmates with developmental disabilities in need of comprehensive assessment as well as social and vocational skill building prior to entering the regular population. Instruction is provided in the areas of Survival/ Social Skills, Horticulture/Grounds Maintenance, Compensatory/Adult Basic Education, Leisure Skills, and Vocational Skill Building. Inmates who demonstrate the ability to function within the regular population are transitioned into the general population at the Pender Unit prior to being reassigned. The program is open-ended, allowing inmates to progress at their own rate. Those felt to be at risk in the regular population may remain at the Unit for the duration of their classification in medium custody. Inmates who have behavioral problems or are unable to function within regular units may be housed in the inpatient MH unit at Central Prison or in the residential mental health program located at Eastern Correctional Institution, Hoke Correctional Institution, or Foothills Correctional Institution. Female offenders with similar needs are housed in the inpatient mental health program at NCCIW. Aftercare Plans are developed for those inmates who need assistance transitioning back into the community. Efforts are made to coordinate services through the local DD staff in the county to which the inmate will be returning.

Substance Abuse Services

The DOC offers substance abuse services (SAS) in the form of Drug Alcohol Recovery Treatment (DART) where participants are involved in extensive follow-up after treatment. DART programs are normally offered in a medium security prison where DART program space is separate from the general population housing. A specific plan is developed for each inmate's follow-up, including active involvement in Alcoholics Anonymous, Narcotics Anonymous, community resources and personal sponsorship. Treatment programs make extensive use of inmates working in the role of ancillary staff, peer counselors, role models or group leaders. Additional resource staff includes community volunteers, contractual employees and interns from local universities. In accordance with state guidelines for service contracts, the division has also established private drug and alcohol treatment centers which facilitate the transition back into the community for inmates who have completed initial intensive treatment and aftercare services.

Another SA program offered by the DOC is Residential Substance Abuse Treatment (RSAT), which involves three to four hours of daily chemical dependency treatment. Programs follow a three phase schedule that begins with the intake/orientation phase. Lasting up to eight weeks, this phase focuses on the tasks of entering treatment; learning the language and behavioral expectations of each program allows inmates to begin taking ownership of the problems that their chemical use has created for them, their families and their communities. Phase two focuses on providing participants with a thorough and current education regarding the effects of using, abusing and becoming dependent of alcohol and/or drugs. Criminal and Addictive Thinking is presented to

provide the link between the participants' involvement with alcohol and drugs and their criminal lifestyle choices. The final phase of treatment usually takes place in the last 60 to 90 days of an inmate's sentence. This phase focuses on relapse prevention planning and release and reintegration needs. The RSAT Program staff coordinates a three-month post release community transition aftercare program.

Aftercare Planning

The goal of cross-collaboration between service providers within the prison system and private providers is to provide a smooth transition for inmates when they re-enter the community. The process should begin approximately six months prior to the inmate's release when the inmate and, if appropriate, his/her family, a social worker and other members of the institutional treatment team completes an aftercare plan to assess the inmate's MH, medical care and other social service needs upon release. A social worker then completes a form with referrals to relevant local service agencies in the community to which the individual will return.

However, it is often difficult to determine a release date, and planning is sometimes a last minute effort on the part of staff who are involved with community interagency councils assisting in planning for the return of inmates with DD into the community. A variety of program and job activities are available to inmates. Some restrictions apply in that the same programs and jobs are not available at all units across the state, and there are some restrictions for those with poor health. Only a few programs are currently available which address the specific needs of inmates with mental retardation. Compensatory Education and Horticulture are two areas in which special services are available at some units. Many are able to acquire job assignments, usually as a janitor or groundskeeper. Vocational Rehabilitation services are available for some inmates eligible for work release. More program and vocational options are needed for inmates with DD.

III. Audit Process and Methodology

Currently, the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services (the Commission) adopts standards for the delivery of MH and DD services to inmates in the custody of the DOC. In keeping with its statutory mandate, the Secretary of Department of Health and Human Services (DHHS) has delegated responsibility for monitoring to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS).

MH program reviews of the DOC were first conducted by the Department of Health and Human Services Mental Health, Developmental Disabilities and Substance Abuse Services (DHHS-MH/DD/SAS) in 1979. The review process has evolved from its inception nearly thirty years ago. The current process was outlined by the Secretary of the Department of Health and Human Services (DHHS) who chose the DMH/DD/SAS to monitor the DOC's implementation of the Commission's SA standards. At the request of the DOC's Director of Mental Health Services in 2004, a review of inpatient and residential programs occurs annually and a review of outpatient services bi-annually. Every year, a rotating review of correctional sites is chosen which represents each level of service and provides a significant sample of both the inmate population and custody levels. The selection process insures that all facilities are visited at least once every three years.

The Commission develops and maintains standards that enable rehabilitative programs to attain accreditation. Beginning in late 2001, the review team from DMH/DD/SAS was asked to begin utilizing standards established by the Commission on Accreditation of Rehabilitation Facilities (CARF) as guidelines for its reviews. Screenings, assessments and case planning are required components of a criminal justice treatment program under the CARF standard. According to their mission statement, CARF promotes the quality, value, and optimal outcomes of rehabilitative services. See Appendix B for a chart of the CARF Behavioral Health Standards. In 2004, the Review Team from DHHS, in collaboration with the Division of Alcohol and Chemical Dependency Programs, developed a compliance review instrument based on the CARF standard by which to review SAS.

A review team consisting of two reviewers from the Assurance Unit of the Accountability Team of the DMH/DD/SAS is assigned the responsibility of reviewing MH/DD/SAS as separate components in order to assess the level of service delivered within the DOC facilities. Prior to reviews, a courtesy phone call is made to the facility to discuss the agenda for the upcoming audit; this is followed by a fax containing the agreed upon agenda for the audit. The audits are three pronged and include:

1. a systematic review of twenty randomly selected mental health records that have a documented DSM IV- R diagnosis
2. observation and tour of the interior and exterior grounds of the facility
3. staff interviews

Individual facility reports are completed following each site review. The reports contain audit findings for the applicable standards and are submitted to the Division of Alcoholism and Chemical Dependency Programs (DACDP) for follow up. Copies of the individual reports and other documents referenced in this report are available upon request.

IV. Overview of 2007 Audit of Findings

The facilities reviewed in the 2007 Prison Audits yielded data pertaining to services for inmates with mental health concerns, substance abuse problems, and developmental disabilities. Additionally, the reviews contain data related to aftercare planning and the cross-collaborative efforts between prison staff and private providers. This information is most easily evaluated when broken down into the related categories; the following sections summarize the reviewers' findings.

V. Findings Related to Mental Health Services for Inmates

The correctional facilities reviewed for MH services in 2007 were: Albemarle, Alexander, Duplin, Fountain, Greene, Lanesboro, Lumberton, Maury, Morrison, Nash, New Hanover, Neuse, North Carolina Correctional Institution for Women (NCCIW), Pasquotank, Pender, and Raleigh. See Appendix C for an overview of the level of care and staffing by facility at the time of the reviews. From auditing these facilities, the review team found a strong relationship between MH, custody, and programs staff. Staff from Albemarle, Duplin, Green, Lumberton, Nash, NCCIW (Residential program), Neuse, and Raleigh all reported during the interview process that these relationships were good. Additionally, the reviewers noted that the MH staff's cooperative relations with the custody and programs staff was good at Alexander, NCCIW (Inpatient), and Pasquotank.

During the audit process, reviewers found several facilities with ongoing MH staffing needs. The staffing shortages encompass both administrative and clinical staff. Many programs have been experiencing ongoing difficulty hiring and/or retaining qualified staff. At the time of the audit several programs, including Lumberton, Nash, and NCCIW (both Inpatient and Outpatient programs), were not fully staffed. At other facilities, such as Lanesboro and New Hanover, staff reported that the caseload is too large for the current allowable staff. While the facilities and the DOC are aware of this shortage, it continues to be an ongoing barrier to service.

The following chart describes a summary of the DOC Division of Alcohol and Chemical compliance rate with MH/DD/SAS Standards. The chart also describes a summary of the DOC Division of Prison Mental Health Section's compliance rate with MH/DD/SAS Standards. This information was documented using a Review Instrument designed by the Program Accountability Team's Program Assurance Unit. The intent of the Review Instrument is to examine compliance with treatment standards. These Standards were promulgated by the Commission on Mental Health, Developmental Disabilities and Substance Abuse Services. The information was obtained through staff interviews, direct observation and reviews of the clinical records. To simplify the analysis, compliance data is summarized using percentages.

Quantitative Summary of Audited Facilities: MH/DD Services Compliance

General Requirements	Compliance Met	Compliance Percentage
Client Records	42/51	82%
Clinical Services	51/51	100%
Facilities Management	51/51	100%
Inpatient Services for Inmates who are Mentally Ill	24/24	100%
Involuntary Administration of Psychotropic Medication	44/45	98%
Medication Services	28/28	100%
Organizational Responsibilities	34/34	100%
Organizational Relations	34/34	100%
Prevention Services	8/8	100%
Privileging/Training of Qualified Professionals	51/51	100%
Protections Regarding Certain Procedures	5/5	100%
Required Staff	85/85	100%
Service Eligibility	17/17	100%
Treatment/Habilitation	114/119	96%

VI. Findings Related to Services for Inmates with Mental Retardation and/or Developmental Disabilities

Inmates with a developmental disability participate in social and vocational skill building. Assessment of adaptive functioning, an essential component of the DD definition, is problematic. Standard assessment instruments contain many areas of functioning which are not observable in the prison environment. DOC has developed the Adaptive Behavior Checklist which is completed within 30 days of assignment to a Unit; however, the instrument has not been standardized. Based on staff interviews and observation, a review of the records, and direct observation services for the developmentally disabled are provided in compliance with MH/DD/SAS Standards.

VII. Findings Related to Substance Abuse Services for Inmates

The Division of Alcohol and Chemical Dependency Program's (DACDP) legislative mandate is to provide comprehensive interventions, programs and services that afford offenders with alcohol and/or drug problems the opportunity to achieve self-actualized recovery. Program improvement initiatives are critical to this process, and a recent achievement has been the implementation and training of staff in all adult male DACDP programs on the New Directions curriculum, which is a nationally recognized and standardized cognitive-behavioral curriculum designed specifically for offenders. Staff training is an ongoing need for incoming and current staff. Reviewers found that supplementary training is needed in regards to grievance procedures, client rights, and ethic appeals for the DART program staff at Black Mountain, Duplin (Residential), Lumberton, and South Central. Additionally, ongoing CARF training was recommended for the DART programs at Black Mountain, Duplin, Lumberton, and Western Youth. The DACDP is actively educating and training staff in CARF administrative and clinical standards and guidelines. DACDP continues to fine tune policies, procedures and clinical practices to comply with CARF standards.

The 2007 Prison Review also found adherence to confidentiality policies to be an area for improvement. The DART programs at Black Mountain, Duplin (Residential), and Fountain all lacked on-site signed staff confidentiality statements for all staff members. Only at one program, Pender's New Directions, did reviewers find a lack of written policies on how to protect confidential records. Several instances of weakness in the confidentiality policies were observed during the review process in relation to technology and system plans and those programs will be continuing to work towards complete compliance.

The need for the DOC's SA programs to implement or update program descriptions was another finding of the prison reviews. The DART programs at Black Mountain, Duplin (Residential), and Lumberton, as well as New Directions at Rowan (Residential) and Western Youth were found to lack current program descriptions. CARF standards require a program description, and these programs must work to comply with those standards before the next review.

The following chart describes a summary of DADCP's compliance rate with CARF Standards. This information was documented using CARF Standards in **Appendix D.** The Division of Alcohol and Chemical Dependency Program's (DACDP) supports the use of CARF Standards as the criteria for examining its Substance Abuse Services. All of the DACDP programs scored 100% compliance rate in meeting CARF Standards for outpatient treatment services. See **Appendix E** for

individual facility ratings. There were weaknesses in the area of information management and performance improvement and documentation, screening and access with a compliance rate of one (1%) respectively. Since the screening process is performed at multiple levels, appropriateness for treatment is often times not clearly communicated.

Audit Tool Sections	SAS COMPLIANCE RATING	COMPLIANCE %
Business Practices	180/220	82%
Info Management & Performance Improvement	19/220	1%
Documentation, Screening, & Access	21/231	1%
Outpatient Treatment	220/220	100%
Criminal Justice	61/240	25%

VIII. Findings Related to the Cross-Collaboration of Aftercare Planning

Adequate cross-collaboration between the DOC and private providers in the area of aftercare planning is an ongoing process. In the course of the 2007 Prison Reviews, auditors found that several of the facilities lacked sufficient cooperative collaboration in regards to aftercare planning. In particular, the DART programs at Duplin, Lumberton, Fountain, South Central, and Black Mountain were found to lack sufficient collaborative efforts. This is an important area for growth since there is a greater likelihood of homelessness for those inmates with severe mental illness and sexual offenses as compared to inmates who do not have diagnoses of severe mental illness or a sexual offense. While current communication between the prisons and the many provider agencies during the discharge process is difficult, the DOC is continuing to work to more effectively cooperate with private providers to better transition inmates with MH/DD/SA needs back into the community.

IX. Barriers to Providing Service within the Division of Prison

1. Staff recruitment and retention is an ongoing concern particularly in the rural areas of eastern NC. This area has a history of difficulty with the recruitment and retention of mental health professionals.

2. Long-term staff vacancies and difficulties with staff retention have resulted in limitations to the number of services that are provided.

3. The lack of bilingual staff must be considered in delivering program services.

X. The Division of Prison's Accomplishments in Regards to MH/DD/SA Services

1. The DOC's purchase of the "New Direction" evidence-based treatment curriculum.

2. The DOC Quality Assurance Director now conducts pre-site visits to assist programs in identifying compliance issues and offers technical assistance.

3. Implementation of telemedicine conferencing, which allows doctors the ability to monitor medication via satellite and gives physicians and inmates increased contact.

XI. Recommendations for Improvements of MH/DD/SA Services within the Division of Prison

1. Increased cross-training and collaboration between prisons and private providers for the delivery of mental health services, necessary medication, and appropriate housing upon an inmate's release from the institution.

2. Correctional agencies need to establish procedures to re-establish Medicaid eligibility immediately upon release for inmates who lose their Medicaid eligibility as a result of incarceration.

3. Additional staff training is needed in regards to the CARF standards; grievance procedures, client rights, and ethic appeals; and confidentiality policies.

4. Data collected concerning MH/DD/SAS should include an analysis of the efficiency and effectiveness of clinical outcomes and how the data can be used to improve delivery of services.

5. The DACDP should implement or update program and policy descriptions to reflect the current methods of treatment and program operations.

6. DACDP should require programs scoring less than 80% compliance to submit quarterly and annual progress reports describing their efforts to improve problems identified during the review. This reporting should continue until at least 80% compliance can be sustained.

7. The DOC and DACDP should seek to secure funds to attract, hire, and train an adequate number of clinicians to handle the mental health caseload.

8. Several older prison internal structures are still in need of support such as repairs, painting lockers, beds and installing air-conditioning.

XII. Appendices

Appendix A - Overview of Prison Facility Mental Health Grade(s) in North Carolina

Facility M Grades by Region		
M Grade	Region	Facility
1	Central	Bladen Correctional Center
1	Central	Columbus Correctional Institution
1	Central	Durham Correctional Center
1	Central	Franklin Correctional Center
1	Central	Guilford Correctional Center
1	Central	Orange Correctional Center
1	Central	Sampson Correctional Institution
1	Central	Sanford Correctional Center
1	Central	Southern Minimum Unit
1	Central	Umstead Correctional Center
1	Central	Warren Minimum Unit
1	Eastern	Carteret Correctional Center
1	Eastern	Gates Correctional Center
1	Eastern	Hyde Correctional Center
1	Eastern	Pamlico Correctional Institution
1	Eastern	Pasquotank Correctional Institution
1	Eastern	Tyrrell Prison Work Farm
1	Eastern	Wayne Correctional Center
1	Eastern	Wilmington Residential Facility for Women
1	Western	Anson Correctional Center
1	Western	Buncombe Correctional Center
1	Western	Cabarrus Correctional Center
1	Western	Caldwell Correctional Center
1	Western	Catawba Correctional Center
1	Western	Charlotte Correctional Center
1	Western	Cleveland Correctional Center
1	Western	Davidson Correctional Center
1	Western	Forsyth Correctional Center
1	Western	Gaston Correctional Center
1	Western	Haywood Correctional Center
1	Western	Lincoln Correctional Center
1	Western	Rutherford Correctional Center
1	Western	Union Correctional Center
1	Western	Wilkes Correctional Center
2	Central	Caswell Correctional Center
2	Central	Dan River Prison Work Farm
2	Central	Hoke Correctional Institution
2	Central	Morrison Correctional Institution
2	Central	Robeson Correctional Center
2	Central	Scotland Correctional Institution
2	Central	Wake Correctional Center

Facility M Grades by Region, cont.		
M Grade	Region	Facility
2	Eastern	Caledonia Correctional Institution
2	Eastern	Odom Correctional Institution
2	Eastern	Pasquotank Correctional Institution
2	Eastern	Tillery Correctional Center
2	Western	Albemarle Correctional Institution
2	Western	Black Mountain Correctional Center for Women
2	Western	Brown Creek Correctional Institution
2	Western	Craggy Correctional Center
2	Western	Marion Correctional Institution
2	Western	Rowan Correctional Center
3	Central	Correctional Center for Women
3	Central	Harnett Correctional Institution
3	Central	Lumberton Correctional Institution
3	Central	McCain Correctional Hospital
3	Central	Polk Correctional Institution
3	Central	Raleigh Correctional Center for Women
3	Central	Randolph Correctional Center
3	Central	Southern Correctional Institution
3	Central	Warren Correctional Institution
3	Eastern	Craven Correctional Institution
3	Eastern	Duplin Correctional Center
3	Eastern	Fountain Correctional Center for Women
3	Eastern	Greene Correctional Institution
3	Eastern	Johnston Correctional Institution
3	Eastern	Nash Correctional Institution
3	Eastern	Neuse Correctional Institution
3	Eastern	New Hanover Correctional Center
3	Eastern	Pender Correctional Institution
3	Western	Avery-Mitchell Correctional Institution
3	Western	Correctional Center for Women
3	Western	Foothills Correctional Institution
3	Western	Lanesboro Correctional Institution
3	Western	Mountain View Correctional Institution
3	Western	North Piedmont Correctional Center for Women
3	Western	Piedmont Correctional Institution
3	Western	Western Youth Institution
4	Eastern	Maury Correctional Institution
4	Western	Alexander Correctional Institution
5	Central	Central Prison
5	Central	North Carolina Correctional Institution for Women

Appendix B - CARF 2006-07 Behavioral Health Standards

CARF 2006-07 Behavioral Health Standards	
Section and Criterion	
1	Business Practices
	Criterion A. Input from Stakeholders
	Criterion B. Accessibility
	Criterion C. Information Management and Performance Improvement
	Criterion D. Rights of Persons Served
	Criterion E. Health and Safety
	Criterion F. Human Resources
	Criterion G. Leadership
	Criterion H. Legal Requirements
	Criterion I. Financial Planning and Management
	Criterion J. Governance
2	General Program Standards
	Criterion A. Program Structure and Staffing
	Criterion B. Screening and Access to Services
	Orientation
	Screening
	Criterion C. Individual Plan
	Criterion D. Transition/Recovery Support Services
	Criterion E. Pharmacotherapy
	Criterion F. Seclusion and Restraint
	Emergency Intervention
	Seclusion or Restraint
	Criterion G. Records of the Persons Served
	Criterion H. Quality Records Review

Section and Criterion	
3	Behavioral Health Core Program Standards
	Criterion A. Assertive Community Treatment
	Criterion B. Assessment and Referral
	Criterion C. Case Management/Services Coordination
	Criterion D. Community Housing
	Criterion E. Community Integration
	Criterion F. Crisis Intervention
	Criterion G. Crisis Stabilization
	Criterion H. Day Treatment
	Criterion I. Detoxification
	Criterion J. Drug Court Treatment
	Criterion K. Employee Assistance
	Criterion L. Inpatient Treatment
	Criterion M. Intensive Family-Based Services
	Criterion N. Out-of-Home Treatment
	Criterion O. Outpatient Treatment
	Intensive Outpatient
	Criterion P. Partial Hospitalization
	Criterion Q. Prevention/Diversity
	Criterion R. Residential Treatment
	Criterion S. Supported Living
	Criterion T. Therapeutic Communities
4	Behavioral Health Specific Population Designation Standards
	Criterion A. Children and Adolescents
	Criterion B. Consumer-Run
	Criterion C. Criminal Justice
	Criterion D. Juvenile Justice
	Criterion E. Addictions Pharmacotherapy

CARF 2006 Behavioral Health Standards, continued	
Section and Criterion	
5	Employment and Community Services
	Criterion A. Individual-Centered Service Planning, Design, and Delivery
	Criterion B. Employment Services Principle Standards
	Services Design for Persons Served
	Services Design for Employers
	The Organization as Employer
	Criterion C. Employment Services Coordination
	Criterion D. Employment Transition Services
	Criterion E. Employment Planning Services
	Criterion F. Comprehensive Vocational Evaluation Services
	Criterion G. Employee Development Services
	Criterion H. Employment Skills Training Services
	Criterion I. Organizational Employment Services
	Criterion J. Community Employment Services
	Job Development
	Job-Site Training
	Job Supports
	Criterion K. Self-Employment Services
	Criterion L. Community Services Principle Standards
	Criterion M. Child and Youth Services
	Criterion N. Community Integration
	Criterion O. Foster Family Services
	Criterion P. Respite Services

Appendix C - Level of Care and Staffing for Mental Health Services by Facility

Level of Care and Staffing for MH Services by Facility (at the time of the 2007 Prison Reviews)		
Facility	**Level of Care**	**Staff**
Albemarle	Outpatient	Psychological program manager; 2 staff psychologist II; a social worker II
Alexander	Residential	Psychological Service Coordinator; Program Manager; Staff Psychologist II; Psychiatrist; Social Worker II; members from Correctional Program Unit assist with MH unit as well
Duplin	Outpatient	Program Manager, staff Psychologist, and Social Worker II
Fountain	Outpatient	Psychiatrist; 2 full-time psychologist; 1 contract psychologist; social worker; rehab therapist; MH nurses (2 vacant)
Greene	Outpatient	2 Psychologist II; 1 Social Worker; 1 Psychiatrist
Lumberton	Outpatient	Psychological program manager; psychological services coordinator; staff psychologist II; social worker II
Maury	Outpatient	Psychiatrist; psychological program manager; 1 staff psychologist II; nursing staff provides assessments and acute/chronic care
Morrison	Outpatient	1 Psychological program manager; 1 staff psychologist II; nursing staff refers inmates for MH svcs
Nash	Outpatient	MH correctional psychological services coordinator; 1 staff psychologist II (vacant), regional social worker; medical records assistant II; psychiatrist
NCCIW (Inpatient)	Outpatient	Psychological program manager; psychiatrist; nusing staff; behavioral specialist; social worker
NCCIW (Residential Program)	Residential	MH Correctional psych Services coordinator, staff psychologist II (vacant), regional social worker; medical records assistant III; psychiatrist
Neuse	Outpatient	Psychological services coordinator; 2 staff psychologist II (both vacant); contractual social worker; psychiatrist; processing assistant III
New Hanover	Outpatient	Staff psychologist II; social worker; nursing services provides med screenings and referrals
Pasquotank	Outpatient	Psychological program manager; 1 staff psychologist II
Pender	Outpatient	Psychiatrist, psychological services coordinator, psychological program manager, social worker, 3 staff psychologist II, 2 contractual staff psychologist, 1 32 hr psychological position (vacant)
Raleigh	Outpatient	Program manager, staff psychologist, and social worker II

Appendix D - Substance Abuse Services 2007 Audit Tool Benchmarks

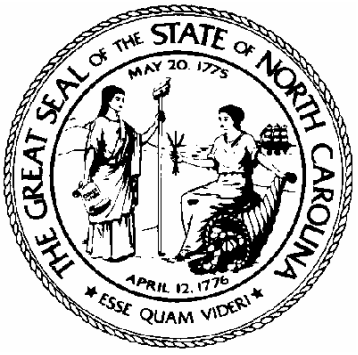
Substance Abuse Services 2007 Audit Tool Benchmarks (Information taken from CARF Standards)
Business Practices
(1) Organization demonstrates input regarding: persons served
(2) Organization demonstrates input regarding personnel
Information Management and Performance Improvement
(3) Appropriate safeguards are applied to protect: patient records and confidential administrative records
(4) Procedures for ensuring that only authorized personnel have access to: records of persons served, administrative records, and electronic documents
(5) Procedures for protecting: confidential information, securing all records, protecting records against hazards
(6) Program structure and staffing (i.e. each core program of the organization has a written plan describing program and philosophy of program goals)
(7) Program receives appropriate medical consultation regarding medically related policies or procedures
Documentation, Screening, and Access
(8) Documentation for Records shall include the following: organized, clear, complete, current, legible, date of assignment, date of service, and name of clinician
(9) Written protocol for established time frames shall include he following: admission note, access, treatment plan/continuation of care plan, and progress notes
(10) Signed and dated progress notes are in the record; (11) Progress Notes are documented according to program description policy
(11) Progress Notes are documented according to program description policy
(12) Treatment or continuation of car plans are in record
(13) screening and access to services
(14) Eligibility based on presenting the problem or need for service
(15) Orientation for the: appropriateness of available services in an interview with the person to be served or referral source, documentation of immediate and urgent need of person served, each person admitted receives an orientation that is appropriate, and organization continuously conducts assessments
(16) Assessments are conducted by qualified personnel who are trained in the use of applicable tools
(17) Individual Planning
(18) Quality Record Review
(19) For all persons leaving services, a written discharge summary is prepared and must included all 11 elements under CARF
Outpatient Treatment
(20) Outpatient treatment programs must have the capacity to provide: group counseling, psycho-education an individual counseling, services in locations that meet the needs of the persons served, program coordinates treatment with other services, and program uses treatment interventions that are recognized in the behavioral health field.

Substance Abuse Services 2007 Audit Tool Benchmarks, continued
Residential Treatment and Therapeutic Communities
(21) Residential Treatment (RT) provides at least 4 hours a day, 7 days a week, which consists of three or more of the following: therapeutic activities, training activities, crisis interventions, advocacy, development of social skills, development of social support network, and/or development of vocation skills
(22) RT is based on the needs of the persons served, services are provided by a coordinated team that includes, at minimum, the following professionals: assigned residential staff members or a plan coordinator, a qualified behavioral health practitioner, and providers of appropriate medical support services
(23) The program provides the following community living components: daily schedule of activities, regular meetings between the persons served and program personnel, opportunities to participate in activities found at home, adequate personal space for privacy, security of property, a home-like and comfortable setting, evidence of individual possessions and decorations, and daily access to nutritious meals and snacks
(24) At least one personnel member immediately available at all times who is trained in first aid, cardiopulmonary resuscitation, the use of emergency equipment
(25) Provisions are made to address the need for smoking or nonsmoking areas, quiet areas, and areas for visits
(26) At least a quarterly review of each person's: plan of services, goals, and progress towards goals
(27) Long-term residential settings, persons served are given opportunities to participate in: social, recreational, and spiritual activities
(28) Therapeutic Community model views the community as the modality for individual change. The program's written plan identities the therapeutic community model through: use of the mutual-help principle, program structure, rules, schedules, responsibilities, behavioral expectations, role modeling, and feedback mechanisms
(29) The program provides treatment throughout the day consisting of the following, based on the needs of the person served: community activities, cultural activities, and/or recreational activities
(30) In a correctional setting, the therapeutic community is provided in a designated space that allows for an appropriate treatment environment
(31) In a correctional setting, efforts are made to accept persons served into the therapeutic community at time that will allow for transition from the treatment program into applicable community-based treatment in a timely manner
(32) In a correctional setting, personnel: have training or experience in the treatment of addictions as well as expertise in working with the criminal justice population
(33) The program provides behavioral services in a correctional setting, such as children/adolescent, criminal justice, an juvenile justice assessment include information on the following: developmental history, medical history, culture/ethnicity, treatment history, and school history
Criminal Justice
(34) Treatment programs within a correctional setting include: partnering with correctional personnel who have decision-making authority and identification of personnel assigned a liaison for ongoing communication
(35) All members of the team are bound by applicable state, federal, and provincial confidentiality laws
(36) The curriculum-based program component for each person served is consistent with his/her cognitive and learning abilities and is consistent with the program's philosophy of treatment

Appendix E - 2007 Substance Abuse Services Audit: Findings Pertaining to the Implementation of CARF Standards

2007 Substance Abuse Services Audit: Findings Pertaining to the Implementation of CARF Standards							
Facility	**Program**	**Business Practices**	**Info Management & Performance Improvement**	**Documentation, Screening, & Access**	**Outpatient Treatment**	**Criminal Justice**	**Overall Comply Rating**
Western Youth	DART	20/20	19/20	0/20	20/20	1/20	60%
Western (Outpatient)	DART	20/20	19/20	0/20	20/20	0/20	59%
Black Mountain	DART	20/20	0/20	0/20	20/20	0/20	40%
Duplin (Residential)	DART	20/20	0/20	0/20	20/20	20/20	60%
Fountain	DART	0/20	0/20	0/20	20/20	0/20	20%
Lumberton	DART	0/20	0/20	0/19	20/20	20/20	34%
NCCIW	DART	20/20	0/20	0/20	20/20	0/20	40%
Pender	NEW DIRECTIONS	20/20	0/20	0/20	20/20	0/20	40%
Piedmont	DART	20/20	0/20	12/20	20/20	0/20	52%
Rowan (Residential)	NEW DIRECTIONS	N/A	N/A	N/A	20/20	0/20	66%
South Central	DART	20/20	0/20	0/20	20/20	20/20	60%
Western Youth	DART	20/20	0/20	9/11	20/20	20/20	69%
Western Youth	NEW DIRECTIONS	20/20	0/20	0/20	20/20	0/20	40%

XIII. Addendum - 2006 Annual Audit Report



2006 Annual Report

Review of the

North Carolina Department of Correction
Division of Alcoholism and Chemical Dependency Programs
Division of Prisons – Health Services
Mental Health Section

General Statute 148-19 (d)

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities
And Substance Abuse Services

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I. BACKGROUND

The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services (hereafter referred to as the Commission) adopts standards for the delivery of mental health and mental retardation services to inmates in the custody of the Department of Correction (DOC).

The Secretary of the Department of Health and Human Services (DHHS) designated the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to monitor the implementation of the Commission of Mental Health, Developmental Disabilities and Substance Abuse Services' substance abuse standards adopted by DOC upon the advice of the Substance Abuse Advisory Council. In addition DHHS is required to send, on an annual basis, a written report of the progress that the DOC has made on the implementation of the above-referenced standards to the Governor, the Lieutenant Governor, and the Speaker of the House of Representatives.

This report is submitted by the Secretary of DHHS in keeping with the North Carolina General Statute 148-19 (d) requirement.

II. REVIEW PROCESS AND METHODOLOGY

A review team consisting of two reviewers from the Assurance Unit of the Accountability Team of the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) are assigned the responsibility of reviewing mental health, mental retardation and substance abuse services as separate components, consistent with the service delivery system of the Department of Corrections.

At the request of the DOC Director of Mental Health Services, a review of inpatient and residential programs occurs annually and reviews of out-patient services bi-annually.

In partnership with staff from both the Division of Prisons (DOP) and the Division of Alcohol and Chemical Dependency Program (DACDP), the review process was initiated with the development of a site review schedule. Prior to the reviews a courtesy telephone call was made to the facility and followed with an agenda. The review itself consisted of interviews with clinical, program and custody staff members, medical record reviews, and facility tours. Prior to the prison site visit, preparation is made to maximize the efficiency of the field review process. A preparation checklist (see Appendix A) for program site visits was developed and followed. This preparation checklist includes a worksheet to help reviewers focus on key areas while examining the core standards.

Individual reports regarding mental health, developmental disabilities and substance abuse services were completed following each site review with specific findings for each of the applicable standards and submitted to the DOC. Copies of the reports and other documents referenced in this report are available upon request.

Clinical services that are required and evaluated by the reviewers as set forth by standards for the delivery of mental health and mental retardation services are:

1. Emergency/Crisis Services
2. Prevention
3. Outpatient
4. Residential
5. Day Treatment
6. Inpatient

The audit involves the review of several elements which are examined for compliance with the DMH/DD/SAS and the Division of Prisons Mental Health Services and the Division of Alcohol and Chemical Dependency Substance Abuse Programs requirements as established under Subchapter 26D of G.S. 148-19(d).

The required standards are listed as follows:

.0202 – Organizational Chart
.0203 – Distribution Standards
.0301 – Psychiatrist
.0303 – Registered Nurse
.0304 – Social Worker
.0305 – Support Staff
.0402 – Information and Outreach Services
.0506 – Supervision of Mental Health and Mental Retardation Staff
.0507 – Privileging of All Professional Staff
.0508 – Employee Education and Training
.0702 – Standards Client Record
.0703 – Record Requirements
.0704 – Confidentiality of Client Record
.0705 – Diagnostic Coding
.0902 – Admission Assessment
.0904 – Treatment or Habilitation Plan
.0905 – Progress Notes
.0906 – Transfer or Discharge
.0907 – Treatment and Habilitation Coordination
.0908 – Release Planning in Residential and Inpatient Services
.1001 – Clinical Services
.1002 – Counseling and Psychotherapy Services
.1003 – Specialized Therapies
.1004 – Testing Services
.1100 – Medication Services
.1102 – Dispensing of Medication
.1103 – Administration of Medication
.1104 – Involuntary Administration of Psychotropic Medication
.1202 - Use of Seclusion
.1203 - Use of Restraint
.1205 - Voluntary Referrals and Transfers

.1206 - Involuntary Referrals and Transfers
.1207 - Transfer to Residential or Inpatient Units
.1401 – Emergency Services
.1402 – Training of Staff

With respect to the above, the review team specifically focused on:

1. a systematic review of randomly selected mental health records, which involves inmates assigned to the mental health unit, with a documented DSM IV- R diagnosis
2. observation and tour of the interior and exterior grounds of the facility
3. staff interviews

III. OVERVIEW OF MENTAL HEALTH SERVICES IN THE DIVISION OF PRISONS

In 1965, mental health services were established within the North Carolina Department of Correction. In 1973 at Central Prison, the first mental health wards for inmates were built.

Mental Health Services established its first sex offender treatment program at Harnett Correctional Institute in 1991 and in 1979, the first reviews of DHHS-MH/DD/SAS began within the Division of Prisons.

The purpose of the Mental Health Reviews is to review for compliance with DOC standards for mental health, mental retardation and substance abuse services. A rotating review of correctional sites representing all levels of services and a wide range of prison populations and custody levels are selected each year. All sites are visited at least once every three (3) years.

The review process has changed over the years. The reviewers currently conduct a multi-discipline interview with the staff, review clinical records, conduct a site tour and a full report is sent to the Division of MH/DD/SAS, Division of Prisons and to the Division of Alcohol and Chemical Dependency Programs.

The Department of Correction makes available mental health assistance to all inmates in need of services assigned to an institution.

Each facility is assigned an M Grade; which determines the type of mental health client that the prison can accept. The chart below lists the prison by region and M Grade:

Chart 1

M Grade	Central	Eastern	Western

M 1			
No mental health treatment provided. Persons assessed to be in need of treatment are transferred to a M2, M3, M4 or M5 unit.	Bladen, Columbus, Durham, Franklin, Guilford, Orange, Sampson, Sanford, Southern Minimum Unit, Umstead, Warren Minimum Unit	Carteret, Gates, Hyde, Pamlico, Pasquotank, Minimum Unit, Tyrrell, Wayne, Wilmington	Anson, Buncombe, Cabarrus, Caldwell, Catawba, Charlotte, Cleveland, Davidson, Forsyth, Gaston, Haywood, Lincoln, Rutherford, Union, Wilkes
M 2			
Outpatient treatment only and is facilitated by a psychologist or clinical social worker for mild mental illness.	Caswell, Hoke, Dan River, Morrison, Robeson, Scotland, Wake	Caledonia, Odom, Pasquotank, Tillery	Albemarle, Black Mountain, Brown Creek, Craggy, Marion, Marion Minimum Unit, Rowan
M 3			Avery- Mitchell, Foothills, Foothills, Minimum, Lanesboro, Mountain View, North Piedmont, Correctional Center for Women, Piedmont, Western Youth
Outpatient treatment only and is facilitated by a psychiatrist, psychologist, or clinical social worker for mild mental illness. No limitations on work assignment.	Harnett, Lumberton, McCain, Polk, Raleigh, Correctional Center for Women, Randolph, Southern, Warren	Craven, Duplin, Fountain, Greene, Johnston, Nash, Neuse, New Hanover, Pender	
M 4		Maury	Alexander
Residential Treatment. Must be approved by mental health staff prior to facility transfer or major program change.			
M 5			
Inpatient Treatment. Must be approved by mental health	Central Prison, North Carolina Institution for		

staff prior to facility transfer or major program change.

Women (NCCIW)

Co-occurring illnesses are common with the adult inmate population. Also, a significant number of juveniles within the correctional setting have both a mental illness and substance abuse problem. While early diagnosis helps to jump-start the treatment process, those youth with a pre-diagnosed mental health condition are at times hindered in their treatment process as some local mental health programs are slow to respond to request for information and minors require parental consent.

Additionally, the adult women's program also reports co-occurring mental health and substance abuse disorders. Medical screenings and processing begins immediately upon an inmate's arrival at a prison diagnostic center.

The diagnostic centers are located at the following facilities:

- Western Youth Institution
- Polk Youth Institution
- Piedmont Correctional Institution
- Neuse Correctional Institution
- Central Prison
- Fountain Correctional Center for Women
- North Carolina Correctional Institution for Women
- Guilford Correctional Center
- Craven Correctional Center

Using a criterion based assessment; medical staff performs a routine medical screening that includes screening for mental health concerns. During the inmate orientation process, inmates are advised about how they may access mental health services. The mandated required mental health services are:

1. Emergency/Crisis Services
2. Prevention
3. Outpatient
4. Residential
5. Inpatient

There are many treatment options available to inmates as needed; these include individual and group treatment, psycho-education, chemotherapy through psychiatry and aftercare planning through social work services.

Inmates may sign up for any number of self-help programs that are available through the mental health and program staff.

Four facilities are available to serve the needs of inmates needing psychiatric services in a residential setting. These are the inmates that are no longer in need of acute inpatient hospitalizations, but are not yet mentally prepared to return to the general inmate population setting.

Appropriate outpatient mental health services are made available as needed to inmates in facilities across the state. Day Treatment programs are provided through outpatient services.

IV. Services for Persons with Developmental Disabilities

The North Carolina Department of Correction and the Division of Prisons provides a range of services to persons with developmental disabilities. These services include interpreters for the deaf, specialized case management for persons with mental retardation, appliances and supports for persons with physical handicaps and communications devices for those with needs for them.

Early identification of inmates who may have mental retardation and or developmental disabilities (DD) is critical to providing appropriate treatment within the Department of Corrections. Case Management Services are provided to monitor individuals with developmental disabilities who are assigned to the Department of Correction.

Developmental Disabilities case management addresses five areas of services to the DD inmate. They are:

1. Orientation
2. Introduction
3. Education
4. Representation
5. Evaluation

It should be noted that this report references “mental retardation” rather than Developmental Disabilities (DD)” even though services of DACDP and DOP are provided to persons with all developmental disabilities.

V. Overview of Services in the Division of Alcohol and Chemical Dependency Programs

The Division of Alcohol and Chemical Dependency Program's (DACDP's) legislative mandate is to provide comprehensive interventions, programs and services that afford offenders with alcohol and or drug problems the opportunity to achieve self-actualized recovery. The Division administers both Drug and Alcohol Residential Treatment (DART) programs, Residential and Substance Abuse Treatment (RSAT) programs and Substance Abuse Outpatient Services.

Beginning in late 2001, the review team from DMH/DD/SAS was asked to begin utilizing standards established by the Commission on Accreditation of Rehabilitation Facilities (CARF) as guidelines for its reviews. According to their mission statement, CARF promotes the quality, value, and optimal outcomes of rehabilitative services. The Commission develops and maintains standards that enable rehabilitative programs to attain accreditation. These standards are from the involvement of providers, consumers, and purchasers of services. Screenings, assessments and case planning are required components of a criminal justice treatment program under the CARF standards**.**

In 2004, the Review Team from DHHS in collaboration with the Division of Alcohol and Chemical Dependency Programs, developed a compliance review instrument based on the CARF standards. Substance Abuse Services were reviewed using the CARF standards. In recent years, DHHS has reviewed facilities that provide substance abuse services (alcoholism and chemical dependency) every two years.

The following is an annual summary of the findings found in the Department of Corrections reviewed by the Assurance Unit of the DMH/DD/SAS related to established standards.

VI. Substance Abuse Services

In an effort to provide quality behavioral health services to inmates with a documented diagnosis, a clinical diagnosis is assigned using the Diagnostic Statistical Manual IV Revised (DSM IV-R) which is a Diagnostic and Statistical Manual of Mental Disorders, Forth Edition. The Division of Alcohol and Chemical Dependency Programs (DACDP) is actively educating and training staff in CARF administrative and clinical standards and guidelines. DACDP continues to fine tune policies, procedures and clinical practices to comply with CARF standards.

It is the belief of DACDP that meeting national accreditation standards offers the opportunity to gain recognition from peers, other professionals, administrators, the court system, probation/parole departments, corrections, law enforcement and the public for their achievement and commitment as a knowledgeable professional in the field of substance abuse counseling, evaluation, and treatment.

Reviews based upon the accreditation protocol must consider factors that influenced the program's capacity to comply with the standards. Such factors include the age of the program start up (e.g., early stage, experienced), institutional restrictions (e.g., degree of isolation of the program from the general population in prisons, prison referral pathways, and classification criteria), limits of funding resources and the presence of appropriate aftercare services. Because of this, the standards included items that assessed the minimal requirements to support the capability of the program.

The review team collects and synthesizes information throughout the review process into documents that can be shared with administrators and staff which help the teams to better comply with national accreditation standards.

There is evidence that substance abuse services within the Department of Correction are integrated and that there is communication between custody, programs, mental health, and the administrative staffs. However, cross collaboration between mental health and substance abuse services is a work-in-progress.

Programs without structured meetings use informal methods of communications such as telephone calls, electronic mail, office visits, impromptu supervision sessions or memorandums.

Substance abuse treatment and education is provided to anyone in prison who is chemically dependent. Screenings and assessments which are provided at the facility are a critical part to referring inmates into treatment programs. An institution with substance abuse services offers inmates multiple avenues to procure a chemical use and abuse screening. Inmates can choose the method most convenient to them.

Treatment programs for substance abuse services vary in terms of setting, length of stay, intensity, modality, and treatment theory of behavior. Within correctional and or community based programs there are many program models and interventions used to address this populations needs, such as outpatient individual and group substance abuse services, short-term inpatient, therapeutic communities, cognitive behavioral interventions, relapse prevention, reality therapy and the Minnesota Treatment Model.

To assist with the inmate's successful reintegration into the community, aftercare planning seeks to ensure continuity of care for every inmate identified as having a mental illness, being developmentally disabled, and or medically needy by creating a complete aftercare plan for each individual. The aftercare plan builds on the inmate's health education that begins either upon intake or diagnosis of a particular health condition.

A major component of this effort is the collaborative approach with private providers of mental health services to better prepare inmates for release and re-entry into the community.

Approximately six months prior to the inmate's release, the inmate and if appropriate their family, social worker along with other members of the institutional treatment team completes an aftercare plan to coordinate the inmate's mental health, medical care and other social service needs post-release. A social worker then completes a form with referrals to relevant local service agencies in the community to which the individual will return.

While the substance abuse screening is generally a one-time event, a substance abuse assessment is an ongoing process. Assessments are repeated throughout treatment and throughout the inmate's involvement in the criminal justice system. Changes in the inmate's severity of addiction and in problems related to addiction, as well as new life problems and crises, require modifications in the treatment plan.

VII. Findings

Chart 2 lists the reviews and compliance findings of twenty-two correctional facilities reviewed from March 2006 through December 2006 for mental health services to persons with mental illness and or developmental disabilities.

Chart 2

Facility Name	MH Service	Level of Compliance
Morrison Correctional Institution	Outpatient	Full Compliance
Raleigh Correctional Center for Women	Outpatient	Full Compliance
Wake Correctional Institution	Outpatient	one record out of compliance as evidenced by no DC-540 in the chart
Odom Correctional Institution	Outpatient	Full Compliance
Caledonia Correctional Institution	Outpatient	one record out- of- compliance as evidenced by the absence of a treatment plan
McCain Correctional Institution	Outpatient	Full Compliance
Polk Correctional Institution	Outpatient	Full Compliance
Foothills Correctional Institution	Outpatient	one record out -of- compliance as evidenced by the absence of a DC- 540 form in chart
North Piedmont Correctional Institution For Women	Outpatient	two records out- of- compliance as evidenced by no DC- 540 in the chart and the inmate not seen within five days of the initial mental health referral
Avery Mitchell Correctional Institution	Outpatient	two records out-of -compliance as evidenced by no DC-548 form or DC-944 form in chart and the inmate not seen within five days of referral
Scotland Correctional Institution	Outpatient	Full Compliance
Johnston Correctional Institution	Outpatient	Full Compliance
Central Prison	Inpatient	seven records out- of- compliance as evidenced by no confidentiality form in the medical record
Western Youth Institution	Outpatient	Full Compliance
Central Prison	Outpatient	There were four records out of compliance as evidenced by white- out used in charts, treatment plan not updated, developmental

Facility Name	MH Service	Level of Compliance
		disabilities orientation not completed within seven days of admission
Southern Correctional Institution	Outpatient	Full Compliance
Piedmont Correctional Institution	Outpatient	seven records out-of -compliance as evidenced by no confidentiality form in chart and no DC-944 treatment plan update in chart
North Carolina Correctional Institution for Women's Residential Services	Residential	four records out-of- compliance as evidenced by no signature on the treatment plan and no confidentiality form in the records
Harnett Correctional	Outpatient	one record out-of- compliance as evidenced by no DC-563 psychiatric note in the record
Alexander Correctional Institution	Outpatient	two records out-of- compliance as evidenced by no confidentiality form in chart
NCCIW	Inpatient	Compliant, however, it is recommended that the treatment plans be uniform in reflecting whether the patient is receiving inpatient or residential treatment during admission into the acute or chronic unit
Randolph Correctional	Residential	one record out- of- compliance as evidenced by an error not corrected according to guidelines and there is no DC-561psychiatric evaluation in the chart

Eleven out- of- twenty-two facilities (50%) reviewed were out- of-compliance with standards. Although the numbers above provides a good baseline of quantitative data, it is not indicative of the quality of treatment services.

The data reviewed and interviews conducted supports that no inmate was denied access to mental health services and that the coordination of care is an integral part of the treatment process.

Chart 3 lists the reviews and compliance findings of four correctional facilities reviewed from March 2006 through December 2006 for substance abuse services to persons with mental illness and or developmental disabilities.

Chart 3

Facility Name	Service	Level of Compliance
DART-Wayne	Substance Abuse	Review Date 11/16/06 Full Compliance

DART-Eastern Outpatient Program Office	Substance Abuse A compliance range/rating of met and not met was applied along with a recommended strategy to approach compliance. The compliance rating score ranged from 91% and above to below 70%. This program received an overall 83%	Review Date 09/17/06 Not Met – as evidenced by no continuing care plan in file, plan not signed by client, no quarterly record review documented, no evidence of active participation of client and under Winner's Circle Program no evidence of client's letter of completion or discharged note
Morrison Therapeutic Community	Substance Abuse This program received all MET and had no out of compliances	Review Date 9/7/06 Full Compliance
North Piedmont Outpatient Program Office	Substance Abuse A compliance range/rating of met and not met was applied along with a recommended strategy to approach compliance. The compliance rating score ranged from 91% and above to below 70%. This program received an overall 80%	Review Date 8/23/06 Not Met – individual plans are not developed with the active participation of the clients and clients do not have active treatment plans in chart

Chart Three indicates that two out of the four facilities (50%) reviewed were out of compliance. Although the numbers above provides an accurate reflection of quantitative data, they are not indicative of the quality of treatment services. The data reviewed and interviews conducted supports that no inmate was denied access to substance abuse services.

VIII. Staff Interviews

Staff members were provided an opportunity to discuss issues and concerns in an open forum and through private interviews. Indoctrination and training in mental health is designed to prepare recruits to positively influence the correctional environment and to insulate them from negative influences. The combined expertise of the Division of Mental Health/Developmental Disabilities/Substance Abuse Services, Division of Alcohol and Chemical Dependency Programs and the Division of Prisons' diverse organizational units enhances the team's capability of solving problems that helps eliminate barriers that develop when separate divisions act independently.

IX. Barriers to Services

Facilities in all locations consistently expressed the same needs with a common and emerging theme of staff recruitment, retention and multiple of coverage sites. Correctional facilities located in the eastern rural areas have a history of difficulties recruiting and retaining mental health professionals.

Services are very limited in those facilities due to long-term vacancies and retention difficulties. Although existing staff at all facilities are qualified, and tele-interpretive services are available, staffing patterns seldom included bilingual individuals.

There is a greater likelihood of homelessness for those inmates with severe mental illness, as compared to inmates who do not have diagnoses of severe mental illness. The process of discharge to communities has been challenged to adapt to the multiplicity of provider agencies, and is currently working to facilitate better the engagement of discharged inmates with community-based services and supports.

X. Accomplishments

The Department of Correction successfully recruited and hired a Director of Mental Health Services and a full- time Quality Assurance Reviewer.

The Division of Alcohol and Chemical Dependency Program recruited and hired a Clinical Director and several facilities recruited psychologists to provide clinical services. Time was spent examining and systematically putting in place a substance abuse treatment curriculum to be used throughout the system of care.

XI. Summary

Mental illness is very common and very disabling for the North Carolina inmate population and treatment may require multiple interventions such as medication, psychotherapy, psycho-education and support.

Survey responses suggest that the Department of Correction may rely on a variety of staff positions to screen and identify inmates with mental illness. During the intake process, the identification of mental illness commonly takes place in many facilities; the intake screening is a multi-stage process in which the initial screening is conducted by non-psychologists, including nurses, counselors, physicians, or social workers.

For those inmates with severe and persistent mental illness, rates of recidivism are high. Inmates identified as needing additional mental health assessments are referred to psychologists, psychiatrists, clinical social workers or a mental health team for a more comprehensive evaluation and diagnostic assessment of their needs and assignment to housing and services. Intra-agency relations between disciplines within the prison facilities require continued effort in coordinating mental health services. This is apparently fostered by the administration's commitment to integrate mental health throughout the various programs offered in the facilities and to proactively engage in the joint planning and disposition in mental health cases involving administrative discipline issues. Internal control systems are designed to minimize potential risks such as prisoner escapes, assaults on staff and prisoners, prisoner suicide, loss of state assets, waste or abuse of state funds, inaccuracies in data systems and noncompliance with laws and rules. Information regarding the availability to services is initially given to inmates via copies of brochures that denote the various mental health services available.

Although staff recruitment and retention are serious issues in several of the facilities, there was no evidence that inmates in need of mental health services were denied services due to a lack of resources. Though the sample size of records reviews was relatively small in comparison to the overall number of admissions into the mental health and substance abuse programs, the screening and assessment process is consistent throughout the system reviews.

Since the last annual report, a number of improvements in mental health and substance abuse treatment have been made. This section summarizes the recommendations drawn from the 2006 site reviews.

There are three key areas in which improvements are noted. They are:

1. The development of the community linkages and partnership with private providers of mental health treatment.
2. Improvements to specific clinical services: including mental health, primary care and substance abuse.
3. Strengthening systems for managing and monitoring change: clinical governance, performance of internal monitoring mechanisms and standard setting.

XII. Recommendations

1. The Division of Alcohol and Chemical Dependency Program (DACDP) must emphasize accountability through quality improvement, surveys, and evaluation efforts. In addition, new technology platforms to enhance substance abuse services are needed.
2. DACDP should require and ensure that programs who score less than 80% submit quarterly and annual progress reports describing quality problems identified by the reviewer or from its own independent reviews and its monitoring and actions taken to correct them.
3. The Department of Correction (DOC) and DACDP need continued support to hire and to train the number of clinicians needed to handle the mental health and substance abuse caseload by paying the salaries required to attract and to retain qualified clinicians and to acquire and upgrade equipment and facilities. Video conferencing should be considered during staff shortages to assist in decreasing travel time to multiple correctional sites.
4. Continuing education for staff should include the key elements of CARF accreditation process for community-based prisons with a behavioral health component and each site needs the current CARF Manual.
5. While the corrections staff report training in self injurious behaviors and some staff report limited training on mental illness, it is counterproductive and dangerous for correctional staff that have little or no training in mental illness to work housing units on the yards, and elsewhere in prison with inmates who have serious mental illnesses. Therefore, it is recommended that on site effective training be provided to all new officers in such areas as: signs of mental illness; different treatment of mental illnesses; effective interaction with mentally ill inmates; defusing potentially escalating situations; recognition of the signs of possible suicide attempts; and training on the safe use of physical restraints for mentally ill offenders.
6. Given the turnover/transfers of inmates and the number of inmates, several of the facilities internal structures are in need of support.
7. Discharge planning efforts should begin months prior to a seriously mentally ill inmates' release to provide them with access to medication and mental health services. Correctional

agencies should also establish procedures by which inmates with mental illness will have access to Medicaid immediately upon release rather than having to wait for periods of time to have the paperwork completed.

8. Inmates with serious mental illnesses should be released from prison with arrangements in place. Links with the Local Management Entities (LMEs) and private providers must be established and maintained or points of entry back into the community mental health system made more accessible for transmitting information and coordinating services. This process is hampered by the lack of appropriate community housing options especially for sexual offenders.
9. Cross training and Memoranda of Agreement (MOA) between treatment providers and other providers is essential. Administrators and program directors should jointly review for the implementation of a standard of practice that is consistent throughout all facilities and that follows national best practices such as the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council of Accreditation Standards (COA) or the American Correctional Association.
10. Collaborative efforts between the community private providers of mental health substance abuse services and facilitation to access needed community resources (i.e. housing, social security, and mental health services) for a smooth and successful transition from a prison term back into the community should continue to be encouraged.

XIII. Appendix A

Checklist for DOP Clinical and Program Staff

- Note: Some forms are case and program specific. As required forms are added; they are to be included in this list.

____ 1. Referral Form DC 540
DC 133-R (resd.or inpt. only)

_____ 2. Confidentiality Form DC 945

_____ 3. Mental Health Assessment DC548
DC 536 (resd. only)

_____ 4. Mental Health Update DC 944

_____ 5. Treatment Plan DC 390

_____ 6. Psychiatric Evaluation DC 561

_____ 7. AIMS DC 528 (inpt. or resd.)

_____ 8. Nursing Adm. Note DC 387 (inpt. or resd.))
or Assessment

_____9. DD Assessment DC 925

_____ 10. Adaptive Behavior Checklist DC 532

_____11. MR Assessment DC564

_____12. DD Orientation DC 542

_____13. Social Work Assessment DC 924

_____14. Social Work Progress Notes DC 508